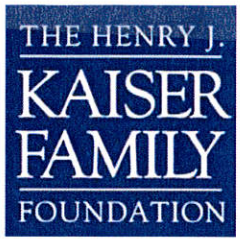
TESTIMONY IS EMBARGOED UNTIL 10:30 AM ON TUESDAY, FEBRUARY 26, 2013



CHANGING MEDICARE'S BENEFIT DESIGN: IMPLICATIONS FOR BENEFICIARIES

Patricia Neuman, Sc.D.
Director, Program on Medicare Policy and
Senior Vice President, The Henry J. Kaiser Family Foundation

Prepared for the Committee on Ways and Means
Subcommittee on Health

"Examining Traditional Medicare's Benefit Design"

February 26, 2013

Chairman Brady, Ranking Member McDermott, and distinguished members of the Subcommittee on Health, I am Tricia Neuman, a Senior Vice President at the Kaiser Family Foundation and Director of the Foundation's Program on Medicare Policy. The Kaiser Family Foundation is an independent, non-profit private operating foundation that is focused on health policy analysis, communications and journalism.

Thank you for the opportunity to testify on the topic of Medicare's benefit design, and the implications of possible changes for beneficiaries, other stakeholders, and program spending. Since the 1970s, the idea of simplifying Medicare's benefit design, while improving protections for those with truly catastrophic expenses, has been under discussion, but developing consensus around an alternative continues to be a challenge. A streamlined benefit design would be easier for beneficiaries to navigate, move Medicare toward the design of typical large employer plans, and provide substantial relief to a small number of beneficiaries with large medical expenses and peace of mind to others. Yet, if designed to be budget neutral or achieve federal savings, a restructured benefit package would be expected to increase costs for the majority of beneficiaries, many of whom have modest incomes, posing a clear policy dilemma.

Background

Medicare provides health insurance coverage for nearly one in six Americans, including 41 million seniors and 9 million younger adults with permanent disabilities. Health insurance coverage is important to people of all ages, but is especially important to people on Medicare. While some are fortunate to enjoy good health, many Medicare beneficiaries have significant medical needs and modest incomes (Exhibit 1). Four in ten beneficiaries live with three or more chronic conditions. About one in four beneficiaries is in fair or poor health and about the same share has a cognitive or mental impairment, such as Alzheimer's disease. More than half live on incomes of $22,500 or less.

Medicare, at 15 percent of the federal budget, has been and continues to be a part of discussions to reduce the federal deficit and debt. However, over the next decade, Medicare spending is projected to grow at a substantially lower rate than it did in the past

decade, at about the same rate as the economy, and at a slower rate than private insurance on a per person basis (Exhibit 2). While growth in per beneficiary spending has been substantially slowed, total Medicare spending is expected to rise as a share of the economy primarily due to a significant increase in the beneficiary population and rising health care costs (that will affect all payers). A wide range of proposals have been put forward to further slow the growth in Medicare spending that could potentially affect providers, plans, and beneficiaries, including options to simplify and restructure Medicare's current benefit design.[1]

Benefits, Supplemental Coverage, and Out-of-Pocket Spending

Medicare was designed to provide coverage of basic health benefits, and over time, has been expanded to include additional benefits, such as prescription drugs and full coverage of preventive services, which are important to the health and well-being of beneficiaries. Yet Medicare has relatively high deductibles and cost-sharing requirements, and a coverage gap for Part D enrollees that will be phased out by 2020. Unlike typical large employer plans, Medicare has no limit on out-of-pocket spending for inpatient and outpatient services. In fact, Medicare remains less generous than the typical large employer preferred provider organization (PPO) plan and the Blue Cross/Blue Shield Standard Option offered through the Federal Employees Health Benefits Program (also a PPO plan).[2]

Most beneficiaries in traditional Medicare have supplemental coverage to help cover some or all of Medicare cost-sharing requirements (Exhibit 3). Employer-sponsored plans (mainly for retirees) remain the primary source of supplemental coverage, providing additional coverage to 41 percent of beneficiaries in traditional Medicare in 2009. Another 21 percent of beneficiaries in traditional Medicare are covered by supplemental insurance policies, known as Medigap. Medicaid plays a key role in providing wrap around coverage for low-income beneficiaries – also 21 percent of beneficiaries in traditional Medicare.

Another 17 percent of all beneficiaries in the traditional Medicare program (12 percent of the total Medicare population) have no source of supplemental coverage. This includes a disproportionate share of beneficiaries with modest incomes, in fair or poor health, and

younger beneficiaries with permanent disabilities.[3] These beneficiaries would be fully exposed to higher deductibles and coinsurance requirements under many of the leading benefit redesign proposals.

A growing number of Medicare beneficiaries, now 27 percent, are covered by Medicare Advantage plans, rather than traditional Medicare. Medicare Advantage plans provide at least the same set of benefits as traditional Medicare, but do not typically have deductibles for services covered Parts A and B, and now include limits on enrollees' out-of-pocket spending (not to exceed $6,700 in 2013).[4] Cost-sharing requirements for various Medicare-covered services tend to vary across Medicare Advantage plans.

Even with Medicare, and supplemental insurance, beneficiaries' tend to have relatively high out-of-pocket health costs. In 2009, half of all Medicare beneficiaries spent 15 percent or more of their income on health-related expenses, including premiums, cost sharing for Medicare-covered services, and services not covered by Medicare; more than one-third of all beneficiaries (39%) spent at least 20 percent of their income on medical expenses that year.[5] Health expenses accounted for nearly 15 percent of Medicare household budgets in 2010, on average – three times the percent of health spending among non-Medicare households (Exhibit 4).

The Current Benefit Design and Recent Proposals

Medicare's benefit design has evolved over time, but from the outset was divided into two parts: Part A (primarily for inpatient hospital and post-acute care) and Part B (for physician and other outpatient services). As of 2006, Medicare also includes the Part D prescription drug benefit that is provided under private stand-alone plans (PDPs) or Medicare Advantage Drug Plans (MA-PDs), but not integrated with other covered benefits under traditional Medicare. This current benefit structure – with separate deductibles for Parts A, B and D, and cost-sharing requirements that vary by type of service – is more complex than a typical large employer-sponsored plan.

Over the years, a number of policymakers and other experts have proposed to simplify the Medicare benefit design. Benefit redesign proposals can be structured to strengthen or weaken the coverage provided by Medicare, and increase or decrease federal spending, depending on the benefit parameters, such as the level of the unified deductible, the limit on out-of-pocket spending, and the extent to which it incorporates financial protections for beneficiaries with low incomes.

In recent years, the idea of simplifying the benefit design has been considered in the context of broader efforts to reduce Medicare spending and to lower the federal deficit and debt. For example, in its 2011 report that examined spending and revenue options to reduce the deficit, the Congressional Budget Office (CBO) evaluated a benefit design that includes a combined Part A/B deductible of $550 (rather than $1,184 per benefit period for Part A and $147 for Part B in 2013), a uniform coinsurance of 20 percent for all benefits covered under Parts A and B, and a limit on out-of-pocket spending set at $5,500, along the lines of the benefit design recommended in 2010 by the National Commission on Fiscal Responsibility and Reform (also known as Simpson-Bowles).[6,7] Additionally, in 2012, the Medicare Payment Advisory Commission (MedPAC) recommended changes to the benefit design that would maintain aggregate cost-sharing requirements for beneficiaries, but would add an out-of-pocket spending limit, replace current coinsurance rates with copayments that may vary by service and provider, and grant the Secretary of Health and Human Services the authority to make value-based changes to Medicare's benefit design.[8] None of the proposals would integrate Part D in the benefit design.

On the one hand, these proposals would simplify the program, position traditional Medicare to look more like private insurance looks today, and provide financial protection to the small share of beneficiaries with truly catastrophic medical expenses whose costs would not otherwise be covered by supplemental insurance. In addition, the limit on out-of-pocket spending could also minimize the need for supplemental coverage and provide peace of mind for all beneficiaries concerned about catastrophic medical bills. But on the other hand, if designed to reduce Medicare spending, or even be budget neutral, such proposals would also likely increase out-of-pocket costs for the majority of beneficiaries, and for some, the increase would be substantial.

What are the Implications of a Restructured Benefit Design for Beneficiaries?

In November 2011, the Kaiser Family Foundation released a report that analyzed the distributional and cost implications of replacing Medicare's current benefit design with a unified deductible for Parts A and B of $550; a 20 percent coinsurance for most Medicare-covered services; and a $5,500 annual limit on out-of-pocket spending.[9] This benefit design is generally consistent with the proposal recommended by Simpson-Bowles-Bowles in 2010 and the option included in the CBO's Budget Options report released in 2011.[10] The following summarizes the results of the analysis, which assumes that the proposal was fully implemented in 2013. Our analysis, conducted with researchers at the Actuarial Research Corporation, focuses on the cost implications for beneficiaries, and illustrates the tradeoffs involved with benefit redesign.

The Effects of Creating a Unified $550 Part A/B Deductible with a 20 Percent Uniform Coinsurance for Most Services, and a $5,500 Annual Limit on Cost Sharing for Part A/B Services.

Restructuring Medicare's cost-sharing requirements in such a fashion would be expected to raise costs for the majority of Medicare beneficiaries while reducing spending for some of the sickest. The effects for any given individual would depend on the particular mix of Medicare-covered services they need and their supplemental coverage.

- **Five percent of beneficiaries in the traditional program (about 2 million) would be expected to see savings as a result of the changes, averaging $1,570 in 2013** (Exhibit 5)**.**[11]
    - Beneficiaries using inpatient hospital and post-acute care, for example, would be more likely to be helped by the alternative benefit design because they are more likely to incur costs that exceed the limit on out-of-pocket spending (Exhibit 6). In any given year, this group would represent a small share of the total Medicare population, although, as noted by MedPAC, a larger share of the Medicare population would be helped by the out-of-pocket spending limit in general if observed over several years.[12]

- However, not all beneficiaries with intensive service use would see a reduction in spending. Beneficiaries with expenses that do not exceed the out-of-pocket limit could end up paying substantially more for their Medicare-covered services due to the new 20 percent coinsurance for home health services and on relatively short inpatient hospital and skilled nursing facility stays (even with a lower Part A deductible).

- **Overall, 71 percent of beneficiaries in the traditional program (about 29 million beneficiaries) are projected to see at least some increase in their out-of-pocket costs, including modest increases in Part B and supplemental insurance premiums, under the revamped system.**
  - For example, beneficiaries in relatively good health, who tend to have a few physician visits in a year but no inpatient care would be expected to have higher out-of-pocket costs, principally because they would face a unified deductible ($550) that is more than three times more than their current law deductible ($147 for Part B in 2013).
  - Five million beneficiaries would be expected to face an increase of $250 or more in their out-of-pocket costs, averaging $660 in 2013; more than one third of these beneficiaries have incomes between 100 and 200 percent of the federal poverty level, a group that is not generally eligible for cost-sharing assistance under Medicaid.

These changes to the benefit design would reduce Medicare spending by an estimated $4.2 billion in 2013, according to our analysis, but aggregate spending among Medicare beneficiaries would rise by $2.3 billion. The proposal would also be expected to result in higher costs for employers ($0.6 billion), TRICARE ($0.2 billion) and other payers ($0.4 billion). Medicaid spending (federal and state combined) would decrease modestly by $0.1 billion in 2013, mainly due to the limit on out-of-pocket spending. Taken together, the changes would result in a net reduction in total health care spending of less than $1 billion in 2013.

The Effects of Raising/Lowering the Out-of-Pocket Limit

Proposals vary in the level at which the out-of-pocket limit for traditional Medicare is set. A lower limit would help more beneficiaries, but erode Medicare savings. Conversely, a higher limit would help fewer beneficiaries, but increase Medicare savings (Exhibit 7).[13]

Assuming a $550 combined A/B deductible and 20 percent coinsurance on most Medicare covered services:

- With a $5,500 out-of-pocket spending limit, five percent of beneficiaries in traditional Medicare would be expected to see a reduction in out-of-pocket spending.
- With a $7,500 out-of-pocket spending limit, three percent of beneficiaries in traditional Medicare would be expected to see a reduction in out-of-pocket spending. With this higher limit, 39 percent of beneficiaries in traditional Medicare would be expected to see costs *increase* by at least $250, compared to 12 percent under the $5,500 limit. The higher limit would increase the federal savings associated with this proposal from $4.1 billion (associated with the $5,500 limit) to $13.2 billion in 2013.
- With a lower $4,000 out-of-pocket spending limit, 30 percent of beneficiaries in traditional Medicare would be expected to see a reduction in spending. The lower limit would result in a $5.1 billion *increase* in federal spending.

The Effects of Combining the Benefit Redesign with Restrictions on First Dollar Medigap Coverage

In addition to restructuring Medicare's benefit design, several recent proposals would prohibit or discourage beneficiaries from purchasing supplemental coverage generally or "first-dollar" coverage more specifically (i.e., insurance that pays upfront cost-sharing requirements for beneficiaries, such as the Part A or Part B deductible). For example, Simpson-Bowles would prohibit Medigap policies from covering the full deductible and would limit Medigap coverage above the deductible – in conjunction with aforementioned changes to the basic benefit design for traditional Medicare.[14] MedPAC also recommended

a premium charge on supplemental coverage (including both Medigap and employer-sponsored plans) in conjunction with changes to the benefit design for traditional Medicare.[15] In his FY2013 Budget, President Obama also proposed to increase Part B premiums for new enrollees who purchase "near first-dollar" Medigap coverage beginning in 2017, although he did not propose to fundamentally restructure the Medicare benefit design.[16]

Prohibiting first-dollar Medigap coverage in conjunction with a restructured benefit package would also create winners and losers, according to Kaiser Family Foundation analysis, under a policy where Medigap policies are prohibited from covering the first $550 in cost sharing and restricted from covering more than 50 percent of cost sharing above the deductible and up to the new spending limit, assuming full implementation in 2013.[17,18] Furthermore, Medigap provides peace of mind to millions of seniors by offering predictable monthly premiums that protect them against unexpected medical expenses and by simplifying the paperwork associated with paying their medical bills.

- **Half of all beneficiaries in traditional Medicare would be expected to see cost increases with Medigap restrictions and the benefit redesign (less than the 71% with expected cost increases under the benefit redesign alone) and nearly a quarter (24%) would be expected to see costs decline (versus 5% with the benefit design alone).** This is a more favorable distribution than the benefit redesign alone because the Medigap restrictions are expected to reduce Medigap premiums (as plans would cover fewer expenses) and reduce Part B premiums because beneficiaries would be expected to use fewer Part B services when faced with higher cost-sharing requirements.
- **The combined benefit redesign and Medigap restrictions would nonetheless increase costs for an estimated six million Medicare beneficiaries by more than $250, with an average increase of $780 in 2013.** More than half of the beneficiaries in this group have incomes below 200 percent of the federal poverty level. Restricting Medigap coverage would require enrollees to pay a greater share of their medical expenses on their own, which would be especially burdensome for enrollees with large medical expenses. For many enrollees with one or more hospitalizations, for example, the increase in cost-sharing requirements would more than offset any reductions in Part B and supplemental premiums.

The primary justification for these proposals is the view that supplemental coverage, especially first-dollar coverage, drives up Medicare spending by insulating enrollees from the cost of the services they use.[19] Numerous studies have demonstrated that increases in cost-sharing result in decreases in utilization. However, the literature also confirms that people forego both necessary and unnecessary care, the former of which could lead to health complications and additional costs in the long run. Research also suggests that, while cost sharing may affect the decision of whether to seek care, it has a smaller impact on the intensity of care provided, and it may have a smaller impact on the use of certain services.[20] For these and other reasons, Medicare is moving forward with demonstrations to test various delivery system and payment reforms that aim to change the incentives of providers, rather than relying primarily on increasing beneficiaries' financial obligations.[21]

Considerations for Low-Income Beneficiaries

This analysis does not consider the effects of strengthening protections for low-income beneficiaries, in conjunction with a benefit redesign. Today, many Medicare beneficiaries with modest incomes do not qualify for Medicaid's assistance with premium, cost-sharing, and other benefits because they do not meet the eligibility criteria. These beneficiaries would be especially hard hit by higher cost-sharing obligations, with or without the additional Medigap changes.

Some have advocated an approach that would shield those with relatively low incomes from an increase in Medicare deductibles and cost-sharing requirements. One approach for mitigating the effect on low-income beneficiaries would be to federalize premium and cost-sharing assistance and to raise income and asset eligibility levels, using the Part D low-income subsidy model as an example. Eligibility levels for Part D low-income subsidies are generally less restrictive than eligibility levels for assistance with Medicare premiums and cost-sharing under Medicaid and the Medicare Savings Programs.

Such an approach would provide stronger protections for low-income beneficiaries and alleviate some of the fiscal pressure on states by reducing spending by state Medicaid programs that currently cover Medicare premiums and cost sharing for eligible low-income Medicare beneficiaries. However, doing so would also erode expected federal savings or even lead to an increase federal spending.

Conclusion

Medicare today enjoys broad support among the public, and a large majority of seniors say the program is working well (Exhibit 8). Nonetheless, it is unlikely that Medicare's current benefit design is the one that would be drafted if the program were being created anew today. Further, with high cost-sharing requirements and no limit on out-of-pocket spending, the majority of beneficiaries have supplemental coverage.

Several recent benefit redesign proposals would provide real help to a small share of the Medicare population, but raise costs for the majority of beneficiaries – many of whom have modest incomes and devote a relatively large share of their incomes and household budgets towards health-related expenses. Finding an approach that will streamline benefits, coax beneficiaries toward high-value providers and services, provide greater protections to those with relatively high cost-sharing expenses, all without shifting excessive costs onto seniors, remains a challenge, particularly in a deficit reduction context.

---

[1] Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future*, January 2013, available at: http://www.kff.org/medicare/8402.cfm.

[2] Kaiser Family Foundation, *How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?: A 2012 Update*, April 2012, available at: http://www.kff.org/medicare/7768.cfm.

[3] Kaiser Family Foundation, *Examining Sources of Supplemental Insurance and Prescription Drug Coverage Among Medicare Beneficiaries: Findings from the Medicare Current Beneficiary Survey, 2007*, August 2009, available at: http://www.kff.org/medicare/7801.cfm.

[4] Half of all Medicare Advantage enrollees were in a plan with a limit at or below $3,400 in 2012. Kaiser Family Foundation, *Medicare Advantage 2012 Spotlight: Enrollment Market Update*, June 2012, available at: http://www.kff.org/medicare/8323.cfm.

[5] Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2009 Cost and Use file.

[6] Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options*, March 2011, available at: http://www.cbo.gov/publication/22043.

[7] Simpson-Bowles also recommended a combined $550 deductible and a uniform 20 percent coinsurance rate. However, while the CBO option included an out-of-pocket spending limit of $5,500, Simpson-Bowles recommended an out-of-pocket spending limit of $7,500, with a five percent coinsurance rate for expenses between $5,500 and the spending limit. The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, available at: http://www.fiscalcommission.gov/news/moment-truth-report-national-commission-fiscal-responsibility-and-reform.

[8] MedPAC also recommended placing a surcharge on supplemental plans, including Medigap and employer-sponsored retiree plans. While MedPAC recommended these broad features of a new benefit design, they did not suggest specific parameters (such as specific copayment amounts). Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

[9] Kaiser Family Foundation, *Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending*, November 2011, available at: http://www.kff.org/medicare/8256.cfm.

[10] Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options*, March 2011, available at: http://www.cbo.gov/publication/22043. The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, available at: http://www.fiscalcommission.gov/news/moment-truth-report-national-commission-fiscal-responsibility-and-reform.

[11] Our analysis only defines beneficiaries with increases or decreases in out-of-pocket spending as those with changes in spending of $25 or more.

[12] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

[13] Kaiser Family Foundation, *Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending*, November 2011, available at: http://www.kff.org/medicare/8256.cfm.

[14] The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, available at: http://www.fiscalcommission.gov/news/moment-truth-report-national-commission-fiscal-responsibility-and-reform.

[15] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

[16] Office of Management and Budge, *Fiscal Year 2013 Budget of the U.S. Government*, February 2012, available at: http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf.

[17] Kaiser Family Foundation, *Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending*, November 2011, available at: http://www.kff.org/medicare/8256.cfm.

[18] The Kaiser Family Foundation also analyzed the impact of Medigap restrictions independent of benefit redesign: Kaiser Family Foundation, *Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs*, July 2011, available at: http://www.kff.org/medicare/8208.cfm.

[19] As an example of research exploring the impact of supplemental coverage on Medicare spending, see: Christopher Hogan, Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly, June 2009, available at: http://www.medpac.gov/documents/Jun09_SecondaryInsurance_CONTRACTOR_RS_REVISED.pdf. MedPAC also provides a summary of other research on this subject: Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

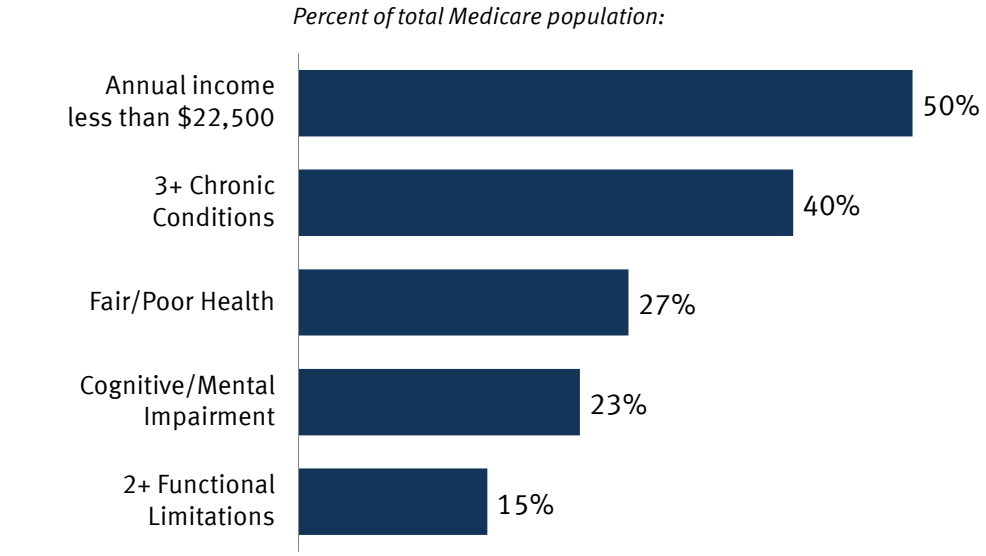
[20] Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcomes*, December 2010, available at: http://www.rwjf.org/content/rwjf/en/research-publications/find-rwjf-research/2011/12/cost-sharing--effects-on-spending-and-outcomes.html and Mathematica Policy Research, Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature, March 2006, available at http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf.

[21] After reviewing whether Medigap Plans C and F should be modified to include nominal cost sharing (rather than cover both the A and B deductibles), the National Association of Insurance Commissioners (NAIC) recommended that "no changes should be made to Plans C and F at this time," and that they did not agree "with the assertion being made by some parties that Medigap is the driver of unnecessary medical care by Medicare beneficiaries." National Association of Insurance Commissioners, *Letter to Health and Human Services Secretary Kathen Sebelius*, December 2012, available at: http://www.naic.org.

Exhibits

Exhibit 1

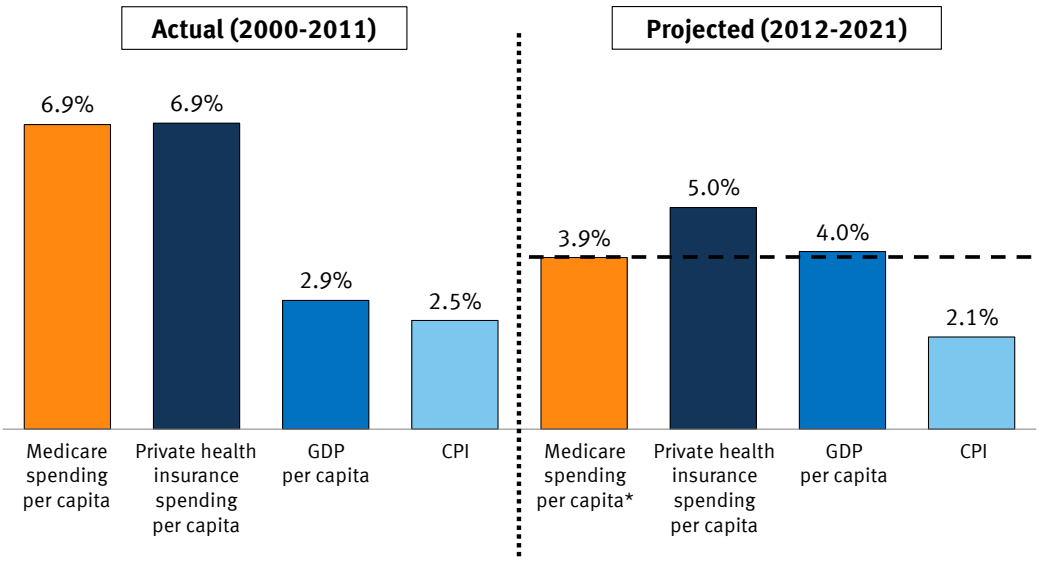
Many Medicare beneficiaries have significant health needs and low incomes



SOURCE: Urban Institute and Kaiser Family Foundation analysis, 2012; Kaiser Family Foundation analysis of the Medicare Current Beneficiary 2009 Cost and Use file.

Exhibit 2

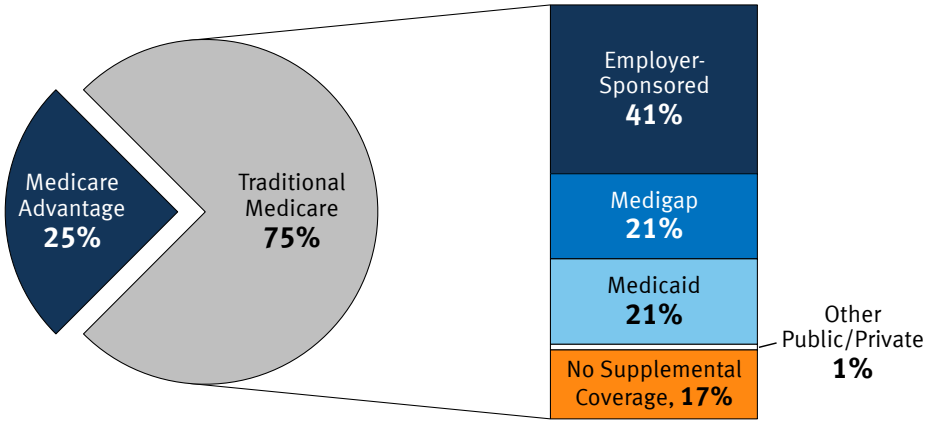
Medicare is projected to grow slower than the economy or private insurance on a per capita basis



NOTE: *Assumes no reduction in physician fees under Medicare between 2012 and 2021.
SOURCES: Kaiser Family Foundation analysis of data from Boards of Trustees, Bureau of Economic Analysis, Congressional Budget Office, Centers for Medicare & Medicaid Services, U.S. Census Bureau.

Exhibit 3

Most beneficiaries in traditional Medicare have some form of supplemental coverage; others are in Medicare Advantage



Total Number of Beneficiaries, 2009:
47.2 Million

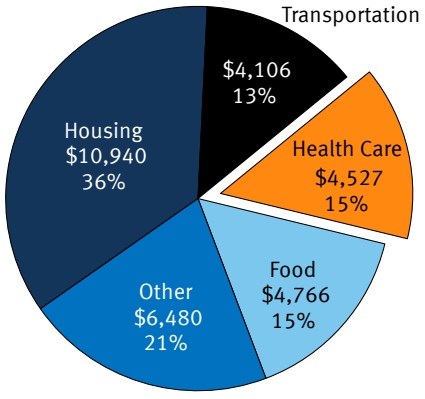
Beneficiaries with Traditional Medicare, 2009:
35.4 Million

NOTE: Numbers do not sum due to rounding. Some Medicare beneficiaries have more than once source of coverage during the year; for example, 2% of all Medicare beneficiaries had both Medicare Advantage and Medigap in 2009. Supplemental Coverage was assigned in the following order: 1) Medicare Advantage, 2) Medicaid, 3) Employer, 4) Medigap, 5) Other public/private coverage, 6) No supplemental coverage; individuals with more than one source of coverage were assigned to the category that appears highest in the ordering.
SOURCE: Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary 2009 Cost and Use file.

Exhibit 4

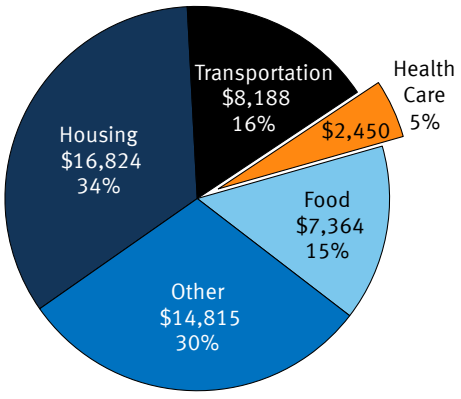
Health expenses account for a relatively large share of Medicare beneficiaries' household budgets

Medicare Household Spending



Average Household Spending = $30,818

Non-Medicare Household Spending



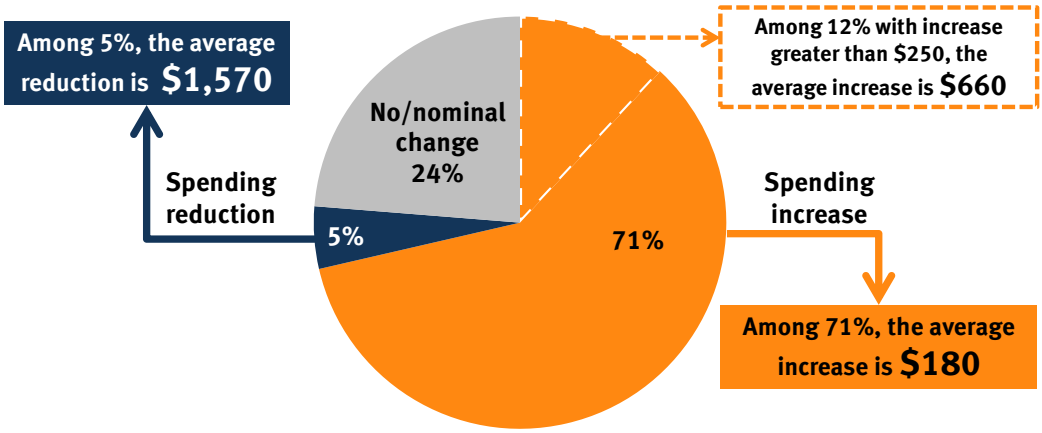
Average Household Spending = $49,641

SOURCE: Kaiser Family Foundation analysis of the Bureau of Labor Statistics Consumer Expenditure Survey Interview and Expense Files, 2010.

Exhibit 5

A small share of Medicare beneficiaries pay less with a restructured benefit design; most would face higher costs

Assumes $550 deductible, 20% coinsurance for all services, $5,500 cost-sharing limit



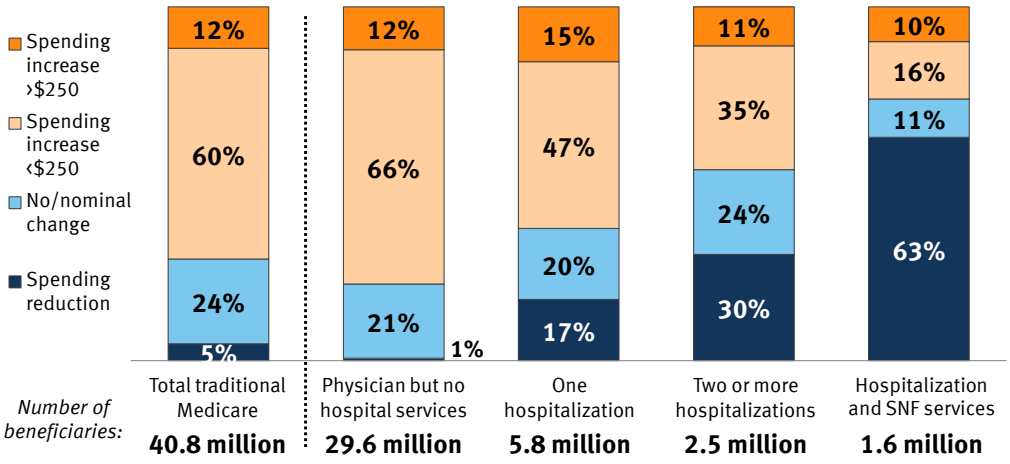
Total beneficiaries in traditional Medicare, 2013 = 40.8 million

SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: Out-of-pocket costs includes premiums and cost-sharing requirements. No/nominal change group includes beneficiaries with changes in spending no more than ±$25.

Exhibit 6

Most beneficiaries using inpatient and SNF care would have lower costs; they account for a small share of the Medicare population

Assumes $550 deductible, 20% coinsurance for all services, $5,500 cost-sharing limit

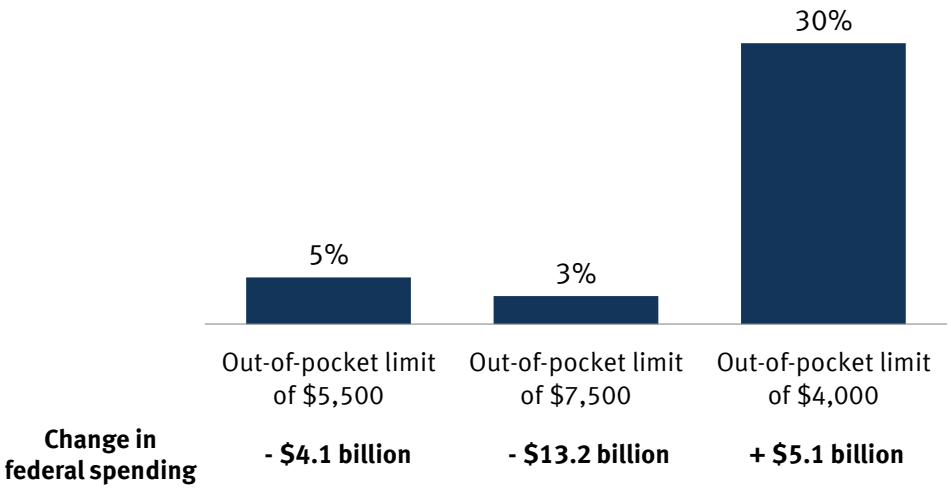


SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.
NOTES: FFS is fee-for-service. SNF is skilled nursing facility. Out-of-pocket spending includes premiums and cost-sharing requirements. No/nominal change group includes beneficiaries with changes in spending no more than ±$25. Users of hospitalization and SNF services are a subset of the 8.2 million beneficiaries with one or more hospitalization. Amounts may not total 100% due to rounding.

Exhibit 7

Share of beneficiaries expected to see a decrease in out-of-pocket spending varies by the level of the out-of-pocket limit

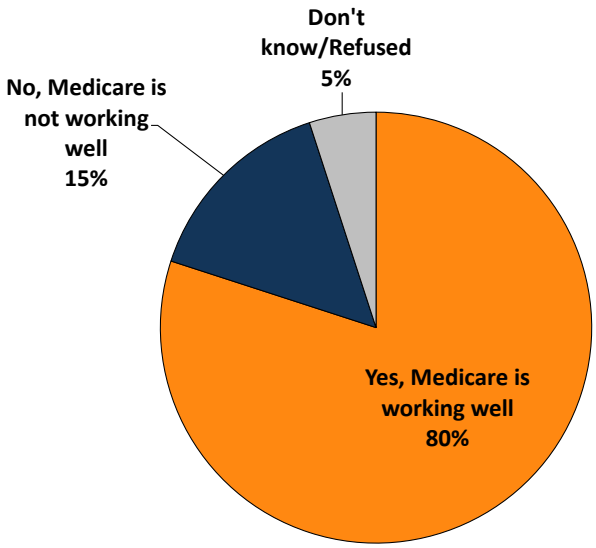
Alternative benefit design, 2013 = $550 deductible, 20% coinsurance for all services, plus out-of-pocket limit



SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation.

Exhibit 8

The vast majority of seniors say Medicare is working well



SOURCE: Kaiser Family Foundation/Robert Wood Johnson Foundation/Harvard School of Public Health, The Public's Health Care Agenda for the 113th Congress (conducted January 3-9, 2013)